# Motivating treatment-resistant clients in therapy

*by* ***Denise L. Preston*** *and* ***Stafford Murphy***[1]

***The effectiveness of psychotherapy in non-correctional settings has been actively debated over the last 40 years. The earliest reviews of treatment outcome studies suggested no difference in recovery rates between treated and untreated patients, regardless of type of patient under study, outcome measure used or method of therapy employed.[2] More recent reviews have indicated that, on average, patients undergoing psychotherapy improve more quickly and to a greater degree than untreated patients with no advantage for any particular type of therapy.[3] Subsequent studies have attempted to identify specific variables relating to positive therapeutic outcome, including an examination of client, therapist and therapy variables. Some of the numerous methodological problems inherent in this research are the selection of convenient populations of study, variability in the training and experience of clinicians and difficulties in operationally defining treatment outcome measures and in monitoring outcome at varying times after treatment. Even in the face of inherent problems, these studies point to important client and therapist variables that potentially have an impact on the efficacy of treatment with treatment-resistant clients.***

## Effectiveness of psychotherapy

Two client variables that seem to be moderately related to treatment outcome are client openness, or non-defensiveness, and motivation for treatment. Clients who are more open and less defensive tend to demonstrate more favourable treatment outcomes than those who are not. In addition, while motivation for treatment is inconsistently related to treatment outcome, it appears that motivation developed during treatment is more predictive of positive treatment outcome than motivation a client may have before treatment. However, motivation for treatment is difficult both to define and measure. Given its apparent significance to treatment gain, the development of theoretically relevant, empirically sound and clinically useful measures of motivation would be a useful endeavour. These measures would enable an examination of issues, such as the importance of the degree of change in motivation during treatment as compared to a minimum "threshold" level of motivation, either before or during treatment.

Three therapist variables that appear to relate to treatment outcome are therapist experience, competence and emotional well-being, all three being related in the expected direction.

The most important therapy variable relating to treatment outcome is a therapeutic alliance (a positive interpersonal relationship) between clinician and client. Therapeutic alliance accounts for most of the variance in treatment outcome research and seems to be more important than the specific intervention used.[4] Of course, therapeutic alliance is contingent on the therapist qualities noted above as well as others such as warmth, genuineness and empathy,[5] but more important, it is contingent on the client's ability to establish positive interpersonal relationships.

## Effectiveness of correctional treatment

A similar debate exists concerning the effectiveness of correctional treatment.[6] Although early reviews concluded that "nothing works," more recent studies have been more positive and have identified some principles of effective correctional programming. Andrews and Bonta[7] conclude that treatment should be delivered to higher risk offenders, target criminogenic needs, be based on cognitive-behavioural or social learning theories, and consider the principles of risk, need and responsivity. They also conclude that treatment must entail consideration of therapist and therapy variables such as the relationship and contingency principles. The relationship principle posits that a positive therapeutic alliance between clinicians and offenders has the potential to facilitate learning. Therapist qualities that contribute to this alliance include being open, enthusiastic, flexible, attentive and understanding, and demonstrating acceptance, respect and caring for offenders. The contingency principle holds that clinicians must set and enforce agreed-on limits to physical and emotional intimacy, as well as clear anticriminal contingencies such as effective reinforcement for prosocial behaviour and disapproval for antisocial behaviour.

It appears, then, that the development of a therapeutic alliance is of primary importance to the effectiveness of both non-correctional and correctional treatment. As already mentioned, however, the development of this alliance depends most notably on the client's capacity to establish and maintain meaningful interpersonal relationships. This is a major impediment for those whose lives have revolved around mistrust and fear of, or indifference to, others.[8] Some of the

diagnoses applied to such individuals are schizophrenia, borderline personality disorder, antisocial personality disorder and psychopathy. A common label applied to these clients is "treatment resistant."

A review of Correctional Service of Canada offender files would reveal that these diagnoses and labels abound. Reviews of treatment efforts with such offenders indicate that they tend to: 1) be less motivated for treatment; 2) be more resistant or non-compliant while in treatment; 3) have higher attrition rates; 4) demonstrate fewer positive behavioural changes while in treatment and; 5) possibly demonstrate higher recidivism rates after participating in treatment.[9] Given the substantial risk that these offenders may commit further violent offences, it is imperative that clinicians make every effort to motivate clients to commit themselves to treatment and to deliver this treatment in ways that maximize the likelihood that clients will make important behavioural changes.

## The process of change

Clinicians have traditionally viewed motivation as a relatively fixed personality trait and so have had a tendency to become demoralized when working with treatment-resistant clients. A more effective way to conceptualize motivation is as a state of readiness to change. Following from this, the purpose of treatment is to help clients progress from one state to another. Evidently, what clinicians do to facilitate movement between states depends on the client's state of readiness. Similarly, the amount of progress demonstrated in moving from one state to another depends on the client's state when treatment begins.

Some[10] have written extensively about the process of therapeutic change, identifying four stages of change. In the precontemplation stage, people do not recognize that they have any problems that require attention or, if they do, have no immediate intention of making changes. People in this stage typically enter treatment under duress, are less open, put forth little effort and are typically quick to relapse to maladaptive behaviours. In the second stage, contemplation, people are aware that they have problems that require attention, but waver between taking no immediate action and expressing or demonstrating some commitment to change. In the action stage, having made a commitment to change, people actively begin modifying their behaviour, experiences and environments. Finally, in maintenance, people have made significant behavioural changes and are actively working to prevent relapse.

This four-stage model implies that it is important for clinicians to expend both time and effort prior to and early in treatment, motivating clients to move from precontemplation to contemplation to action, if necessary. To facilitate this, clinicians must attempt to develop a therapeutic alliance with clients to engage them effectively in treatment.

## Therapeutic engagement of treatment-resistant clients

Many authors[11] have identified therapist qualities that promote the development of a therapeutic alliance. Some authors,[12] however, have suggested specific strategies for the engagement of treatment-resistant clients. While the list is not exhaustive, these authors suggest that clinicians should acknowledge that ambivalence and resistance on the part of clients are natural and understandable. How they handle their clients' resistance determines, in large part, the outcome of subsequent treatment efforts. Clinicians should take an active role in helping resistant clients by, for example, attempting to remove practical and attitudinal obstacles to change. They should, however, maintain a balance between actively helping and having clients assume responsibility for behavioural change. To work with, rather than against, client resistance, clinicians should not attempt to force clients to accept their opinions about the nature of their problems or the appropriate changes to make. Rather, they should invite the client to consider alternative perspectives and information.

Clinicians should provide information and feedback about clients' current situations and the consequences of maintaining their current behaviour. They should also provide information about the likely advantages of changing. In doing so, clinicians can clarify for clients, the discrepancy between current behaviour and important personal goals. Clients may then shift their "motivational balance" in favour of the pros of change versus those of the status quo.

Wherever possible, clinicians should provide clients with choices regarding the type of treatment undertaken and its goals. The agreed-on goals must be reasonable, attainable and prosocial, and clinicians should provide regular feedback concerning clients' attempts to achieve these goals.

Finally, in dealing with resistant clients, clinicians should be empathic. They should seek to understand clients' feelings and perspectives by reflecting and reframing what clients reveal. They should also support and promote clients' feelings of, and efforts toward, self-efficacy. While being empathic toward clients does not necessarily entail condoning their

behaviour, it does preclude a number of counter-therapeutic approaches. Clinicians working with any clients, particularly those considered treatment resistant, should avoid judging, denigrating, labelling or otherwise blaming them. Clinicians can encourage clients to take responsibility for their behaviour without attributing blame. They should avoid playing the role of the "expert" with special capabilities to "fix" them.

Most important, clinicians should avoid argumentation or strong confrontation with treatment-resistant clients. Aggressive confrontation typically results in increased defensiveness on the part of clients and forces them into a position of arguing more strongly in favour of their perhaps misguided opinions. It exemplifies clinicians taking responsibility for bringing about behavioural change in clients.[13]

### Therapeutic engagement of psychopaths

Some of the techniques for therapeutic engagement of treatment-resistant clients may be contraindicated when applied to psychopaths, perhaps the most resistant of clients. As noted by several researchers and clinicians, psychopaths possess a unique cluster of personality characteristics.[14] Most notably, they have a diminished capacity to form meaningful interpersonal relationships although they can effectively mimic such a capacity. This suggests that treatments placing heavy emphasis on the development of a therapeutic alliance between clinicians and clients are likely to fail with psychopathic clients. Moreover, such treatments may be risky to clinicians because they may perceive a false sense of personal safety with psychopathic clients. Psychopaths are grandiose and may demand to see the most senior available staff member. For example, during police investigations they may request to be interviewed by the most senior investigating officer and, in treatment, they may expect to be treated by the most senior clinician.[15] This suggests that they may respond most favourably to characteristics other than the interpersonal qualities of clinicians. Psychopathic clients are also manipulative, and clinicians must be persistent in setting and enforcing limits on their relationships with psychopaths. Clinicians must not protect them from the legal and social consequences of their behaviour[16] and must repeatedly reinforce that, when assessing changes in behaviour, they will be convinced by actions rather than words. Clinicians must be wary of giving psychopathic clients the benefit of the doubt even in seemingly innocuous situations. Psychopaths will perceive clinicians as gullible and, thus, as legitimate targets for future manipulation.

### Applying therapeutic engagement techniques with treatment-resistant offenders

The Persistently Violent Offender (PVO) Treatment Program is a demonstration project developed and funded by the Research Branch of the Correctional Service of Canada. It is a multiyear, multisite, non-residential treatment program currently being piloted at Collins Bay Institution in Ontario. The program targets persistently violent offenders, defined as those having at least three convictions for violent offences. It is based on a social problem-solving theoretical framework and is delivered according to cognitive behavioural principles. It involves 18 weeks of half-time participation.

Given the population in question, most are expected to be treatment resistant. For this reason, the first two weeks of the program constitute a motivational module designed to facilitate participant interaction, commitment and trust. Among other specific topics, participants and therapists generate group rules and complete a cost-benefit analysis of completing the program. The group rules emphasize the positive or negative impact of various behaviours on others. Similarly, the cost-benefit analysis comprehensively examines the short-term and long-term advantages and disadvantages of completing versus not completing the program. This analysis includes the perspectives of participants, their families and significant others, friends, victims and society in general. The module also includes consideration of various obstacles to change, including aggressive non-verbal and verbal communication, aggressive beliefs, substance abuse and impulsivity. Each of these is discussed with an emphasis on how they promote violent behaviour and, conversely, inhibit non-violent behaviour.

Preliminary observations of the first group support the expectation that the PVO program is targetting primarily treatment-resistant offenders. The majority consented to treatment only after many protests about the duration, content and title of the program. Many offenders also argued that they are not persistently violent and that the criterion for program eligibility ought to be five convictions for violent offences instead of the requisite three. The majority have had at least one unsuccessful prior attempt at some form of treatment, and most have received numerous institutional charges for failing to comply with various aspects of their correctional plans. Finally, most of them are extremely confrontational with other members of the group, but primarily with the therapists.

The impact of the motivational module was considerable. No one was discharged from the

program in the first two weeks, perhaps because, after the first week, the therapists removed a major practical obstacle to treatment: they changed the time of the group from the morning to the afternoon. This minor concession resulted in a reduction in tardiness, absenteeism and complaints, and in a significant increase in attention and participation. It was clear that it was the first time that some group members had ever considered some of the issues presented. For example, when discussing communication strategies, some were oblivious to the concept of non-verbal communication or its impact on others. In completing the cost-benefit analysis, most participants failed to consider the impact of violence on anyone other than themselves, and most expressed scepticism about the impact on victims in particular.

Many entered the program claiming that most violent behaviour is spontaneous or even inevitable. By the end of the module, most conceded that distorted thinking plays a role in motivating violent behaviour and that, in most situations, there may be at least one non-violent alternative for problem resolution. Even more encouraging is that some group members expressed enthusiasm about learning new solutions.

These are no small accomplishments for such a resistant group. ■

[1] Denise L. Preston is the Director of the Persistently Violent Offender Program (PVO) at Collins Bay Institution, 455 Bath Road, P. O. Box 190, Kingston, Ontario, K7L 4V9. Stafford Murphy is a therapist in the PVO program.

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